3
16868

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 23049

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
KARL	HEINZ	APPEL	AUGUST 30 1986	12:15PM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
Male	White	Feb. 17, 1929	57 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
New Castle,Pa.	U. S. A.		Cecil Co. MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
PERRY POINT MD	VA MEDICAL CENTER	Field underwriter	State Farm Ins.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO XX	13e. STREET ADDRESS / ZIP CODE
Maryland	Harford	Bel Air		202 Briarcliff Rd. 21014

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Ludwig		Appel	Luise		Sohns

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
yes	1948=1952	204 22 6351	Mrs.D. Joyce Appel, Bel Air, Md. 21014	202 Briarcliff Lane

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) PNEUMONITIS

DUE TO, OR AS A CONSEQUENCE OF

(b) MALIGNANT BRAIN TUMOR

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that X (this hospital) attended the deceased from JULY 21 1986, 19 86, to 8-30-, 19 86 XXXXXXXst XXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX above, (I/we) (did) (did not) view the body after death. And that in (my) (our) opinion death occurred on the date and hour and from the causes stated

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN X	22c. DATE SIGNED
G. Rayson	MD		8-30-86

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
GLENDON RAYSON MD	VAMC, PERRY POINT MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	9-2-1986	Bel Air Mem.Gardens	BelAir Harford Md.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
E.F. LASSAHN F.Home	11750 Belair Rd. P.O. Box 147 KINGSVILLE MD 21087	SEP 3 1986	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

0-16437

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of death.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 23050

1. DECEASED NAME (TYPE OR PRINT) FIRST: Annie	MIDDLE: M.	LAST: Beavers	2a. DATE OF DEATH MONTH: August	DAY: 25	YEAR: 1986
2b. HOUR: 1:30A M					
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH: June	DAY: 23	YEAR: 1911	6. AGE (IN YEARS LAST BIRTHDAY): 75 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia	7b. CITIZEN OF WHAT COUNTRY?: U. S. A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil County MD.		
10. CITY OR TOWN OF DEATH: Elkton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Union Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife	12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Cecil	13c. CITY OR TOWN: Elkton	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS / ZIP CODE: 448 Gallaher Road 21921	
14. FATHER'S NAME FIRST: Henry	MIDDLE	LAST: Mabe	15. MOTHER'S MAIDEN NAME FIRST: Emiline	MIDDLE	LAST: Lawson
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 218-40-2148	17. INFORMANT: Roger Beavers	ADDRESS: 55 Kullen Dr. Newark Del	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Acute Myocard Infarction	
DUE TO, OR AS A CONSEQUENCE OF (b)	ACVD, Hypertension	
DUE TO, OR AS A CONSEQUENCE OF (c)	Diabetes mellitis	

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 5/21/74 19____ to 8/25/86 19____, that (I) (we) last saw the deceased alive on 8/7 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Jui Chih Hsu MD	DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 8/26/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Jui Chih Hsu	22e. ADDRESS: 223 Main St Elkton MD 21921	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: Aug. 27, 1986	23c. NAME OF CEMETERY OR CREMATORY: Gilpin Manor Mem.	23d. LOCATION CITY OR TOWN: Elkton / COUNTY: Cecil / STATE: MD	
24. FUNERAL DIRECTOR NAME: Edward M. Moran	ADDRESS: Gee Funeral Home 259 E. Main St. Elkton MD	25a. DATE REC'D. BY REGISTRAR: AUG 27 1986	25b. REGISTRAR'S SIGNATURE:	

0-16314

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 23051

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
CLIFFORD	L.	BENHAM	August 22, 1986	3:25pm

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
Male	White	2 07 1919	67 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Indiana	USA		Cecil MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Perry Point, Md.	VA Medical Center	Ret. Military Navy	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Md	Cecil	Colora	YES ☐ NO ☒	10 Wine Sap Ct. 21917

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Robert	M	Benham	Gertrude		Risk

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	1940-1959	304-16-5228	Crystal Benham	Same as 13above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardio-respiratory arrest

DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial infarction

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (☒ this hospital) attended the deceased from August 12, 19 86 to August 22, 19 86, that ☒ (we) last saw the deceased alive on August 22, 19 86, and that in ☒ (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Avelina C. Hernandez	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒	8-22-86

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
AVELINA C. HERNANDEZ, M.D.	VA Medical Center, Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	8-25-86	Benham Cemetery	Benham Ripley Indiana

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Foard Funeral Home	Rising Sun, Md.	AUG 26 1986	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and registered by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified before any action is taken.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

00-16408

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 86 23052

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked "Yes," the medical examiner must be notified of the case.

1. DECEASED NAME (TYPE OR PRINT) FIRST: CHARLES	MIDDLE: A.	LAST: BENNETT SR.	2a. DATE OF DEATH MONTH DAY YEAR: 8-19-86	2b. HOUR: M	
3. SEX: M	4. RACE: W	5. DATE OF BIRTH MONTH DAY YEAR: 5 25 08	6. AGE (IN YEARS LAST BIRTHDAY): 78 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MD	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: CECIL MD.		
10. CITY OR TOWN OF DEATH: ELKTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): UNION HOSP.	12a. USUAL OCCUPATION (TYPE OF WORK DONE DURING MOST OF WORKING LIFE): RET LABOR	12b. KIND OF BUSINESS OR INDUSTRY: TRANSPORTION		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD	13b. COUNTY: CECIL	13c. CITY OR TOWN: CHESAPEAKE CITY	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 217 BOHEMIA AVE 21915	
14. FATHER'S NAME FIRST: FRANK	MIDDLE:	LAST: BENNETT	15. MOTHER'S MAIDEN NAME FIRST: ALICE	MIDDLE:	LAST: VANBUSKIRK
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 217-14-5138	17. INFORMANT: ANNA V. BENNETT	ADDRESS: CHESAPEAKE CITY MD	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Severe COPD — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: years
DUE TO, OR AS A CONSEQUENCE OF
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): ASHD.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from Apr 19 80, to Aug 19 19 86, that (I) (last) saw the deceased alive on Aug 19 19 86, and that in (my) (opinion) death occurred on the date and hour and from the causes stated above, (I) (saw) (did) (did not) view the body after death.

22b. SIGNATURE: Wallace Obenshain DEGREE: MD — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: Aug 20, 1986

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Wallace Obenshain, M.D. — 22e. ADDRESS: Cecilton, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: 8-22-86	23c. NAME OF CEMETERY OR CREMATORY: BETHEL	23d. LOCATION CITY OR TOWN: CHESAPEAKE CITY COUNTY: CEC STATE: MD	
24. FUNERAL DIRECTOR NAME: R. T. FORD FUNERAL HOME	ADDRESS: CHESAPEAKE CITY MD	25a. DATE REC'D. BY REGISTRAR: AUG 22 1986	25b. REGISTRAR'S SIGNATURE: Gina Davidson-Henderson	

BP_____

DHMH - 16 50M 4/82
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 86 023053

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST: Reginald / / Bias			2a. DATE OF DEATH MONTH DAY YEAR: August 9, 1986		2b. HOUR: 9:50A M
3. SEX: MALE	4. RACE: BLACK	5. DATE OF BIRTH MONTH DAY YEAR: FEB 26 1911	6. AGE (IN YEARS LAST BIRTHDAY): 75 YRS	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil MD.		
10. CITY OR TOWN OF DEATH: Perry Point	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): PERRY POINT VA. HOSP		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): LETTER CARRIER	12b. KIND OF BUSINESS OR INDUSTRY: GOVT	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
DC	WASH		YES [ ] NO [ ]	1311 DELAWARE AV. D.C. 20024

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST		
ALBERT / / BIAS	ALLIEN / / KIRBY		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): YES	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 578 07 9894	17. INFORMANT: LUCILLE BIAS	ADDRESS: 1311 DELAWARE D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Pancreatic carcinoma

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that [X] (this hospital) attended the deceased from May 13, 19 86, to August 9, 19 86, that [X] (we) last saw the deceased alive on August 9, 19 86, and that in [X] (our) opinion death occurred on the date and hour and from the causes stated above. [X] (we) (did) [XXX] view the body after death.

22b. SIGNATURE DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
Michael Delahunt M.D.	ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [XX] STAFF PHYSICIAN [ ]	8-9-86

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Michael Delahunt, M.D.	VA Medical Center, Perry Point, MD 21902

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	Aug 13, 1986	VA CEM. QUANTICO	QUANTICO, VA

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Jarvitz F.H., 1432 "U" St., NW, Washington, DC.	AUG 12 1986	Julia Bradley Registrar

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked, Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of death.

DHMH - 16 60M 7/84
(VRA 15, 4)

00-15565

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO 88 23054

1. DECEASED NAME (TYPE OR PRINT): John Denny Boggs

2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] MONTH 8 DAY 7 YEAR 1986 — 2b. HOUR

3. SEX: Male — 4. RACE: White — 5. DATE OF BIRTH: MONTH 4 DAY 5 YEAR 07 — 6. AGE (IN YEARS LAST BIRTHDAY): ~~83~~ YRS. — IF UNDER 1 YR. MONTHS DAYS — IF UNDER 24 HRS. HOURS MIN. — 79 years old

2c. DATE PRONOUNCED DEAD: MONTH 8 DAY 7 YEAR 1986 — 2d. HOUR 9:00 P M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania

7b. CITIZEN OF WHAT COUNTRY? U.S.

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil County MD.

10. CITY OR TOWN OF DEATH: Elkton

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 137 Friendship Road

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Painter

12b. KIND OF BUSINESS OR INDUSTRY: Paint

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md. — 13b. COUNTY: Cecil — 13c. CITY OR TOWN: Elkton — 13d. INSIDE CITY LIMITS? YES [ ] NO [ ] — 13e. STREET ADDRESS: 137 Friendship Rd. 21921

14. FATHER'S NAME: FIRST Herman MIDDLE P. LAST Boggs

15. MOTHER'S MAIDEN NAME: FIRST Elizabeth MIDDLE LAST Evans

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): Yes (IF YES, GIVE WAR OR DATES): WWII

16b. SOCIAL SECURITY NO.: 146-03-0553

17. INFORMANT: Ms. Beverly B. Halsey — ADDRESS: Bridgeton New Jersey 50 Lake St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Atherosclerotic heart disease
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Chronic alcoholism, Cachexia

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES [ ] NO [ ]

21a. EXTERNAL CAUSE WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [ ], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ].

ACTUAL SIGNATURE: [signature] — TITLE (SPECIFY): M.D. Deputy MEDICAL EXAMINER — DATE SIGNED: 8-7-86

EXAMINER'S NAME (TYPE OR PRINT): Ivan C Gonzalez-Vitale — ADDRESS: Union Hosp., Elkton MD 21921

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Removal — 23b. DATE: 8-9-86 — 23c. NAME OF CEMETERY OR CREMATORY — 23d. LOCATION CITY OR TOWN COUNTY STATE

24. FUNERAL DIRECTOR NAME ADDRESS: Anatomy Board Balto., Md.

25a. DATE REC'D BY REGISTRAR: AUG 14 1986 — 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM DH 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

+80-15873

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE REGISTRAR

REG. NO. 86 23055

1. DECEASED NAME (TYPE OR PRINT): First Alton; Middle T.; Last Bowes; Jr.

2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] Month 8 Day 3 Year 1986 — 2b. HOUR

3. SEX: Male — 4. RACE: White — 5. DATE OF BIRTH: Month June Day 11 Year 1946 — 6. AGE (IN YEARS LAST BIRTHDAY): 40 YRS. — IF UNDER 1 YR. Months Days — IF UNDER 24 HRS. Hours Min

2c. DATE PRONOUNCED DEAD: Month 8 Day 3 Year 1986 — 2d. HOUR 400 P M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Phila., Pa.

7b. CITIZEN OF WHAT COUNTRY? U.S.A.

8. MARRIED [XX] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil County MD.

10. CITY OR TOWN OF DEATH: Elkton

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 48 Old Chestnut Rd.

12a. USUAL OCCUPATION (TYPE OF WORK DONE DURING MOST OF WORKING LIFE): Machinist- Navy

12b. KIND OF BUSINESS OR INDUSTRY: Yard

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Pa. — 13b. COUNTY: Phila. — 13c. CITY OR TOWN: Phila., — 13d. INSIDE CITY LIMITS? YES [XX] NO [ ] — 13e. STREET ADDRESS: 2615 S. Massey Street 99999

14. FATHER'S NAME: First Alton; Middle T.; Last Bowes

15. MOTHER'S MAIDEN NAME: First Lillian; Middle; Last Kurtz

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): yes — (IF YES, GIVE WAR OR DATES): Viet-Nam

16b. SOCIAL SECURITY NO.: 169-32-9462

17. INFORMANT: Theresa A. Bowes — ADDRESS: 2615 S. Massey St Phila., Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute myocardial infarction
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES [ ] NO [XX]

21a. EXTERNAL CAUSE WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on Autopsy [ ], Inspection [X], Inquiry [ ], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ].

ACTUAL SIGNATURE: [signature] M.D. TITLE (SPECIFY): Deputy MEDICAL EXAMINER DATE SIGNED: 8-3-86

EXAMINER'S NAME (TYPE OR PRINT): Ivan C Gonzalez-Vitali MD ADDRESS: Union Hosp. Elkton MD 21921

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation — 23b. DATE: 8-4-86 — 23c. NAME OF CEMETERY OR CREMATORY: R. A. Ferris Crem. — 23d. LOCATION CITY OR TOWN: 899 Fern Hill Rd, Chester COUNTY: Pa. STATE

24. FUNERAL DIRECTOR NAME: Gee Funeral Home, P.A. ADDRESS: Elkton, Md. — 25a. DATE REC'D. BY REGISTRAR: AUG 12 1986 — 25b. REGISTRAR'S SIGNATURE

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

BP

99999

DHMH - 17
(VS/A15 ME (5))
20M 4/82

00-17304

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 86 23056

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Zaley — MIDDLE: F. — LAST: Brammer

2a. DATE OF DEATH — MONTH DAY YEAR: August 26, 1986

2b. HOUR: 8:15P M

3. SEX: Male

4. RACE: White

5. DATE OF BIRTH — MONTH DAY YEAR: 8 27 12

6. AGE (IN YEARS LAST BIRTHDAY): 73 YRS. — IF UNDER 1 YEAR: MONTHS DAYS — IF UNDER 24 HRS.: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Va.

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil MD.

10. CITY OR TOWN OF DEATH: Perry Point

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Perry Point VA Med. Center

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Ret. Locomotive Eng.

12b. KIND OF BUSINESS OR INDUSTRY: APG

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md.

13b. COUNTY: Cecil

13c. CITY OR TOWN: Colora

13d. INSIDE CITY LIMITS? YES [ ] NO [X]

13e. STREET ADDRESS / ZIP CODE: 719 Harrisville Rd. 21917

14. FATHER'S NAME — FIRST: Clyde — MIDDLE: — LAST: Brammer

15. MOTHER'S MAIDEN NAME — FIRST: Laura — MIDDLE: — LAST: Dodson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): yes — (IF YES, GIVE WAR OR DATES): WWII

16b. SOCIAL SECURITY NO.: 162 09 3205

17. INFORMANT — ADDRESS: VAMC, Perry Point, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Respiratory Failure

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Broncho-pneumonia

DUE TO, OR AS A CONSEQUENCE OF (c): Congestive Heart failure

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES [ ] NO [X]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED — WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION — STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that [XX] this hospital) attended the deceased from 5-31- 19 85 to 8-26- 19 86, that [X] (we) last saw the deceased alive on 8-26- 19 86, and that in [XX] (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did [XX]) view the body after death.

22b. SIGNATURE: Prem Lal — DEGREE: ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [X]

22c. DATE SIGNED: 8-26-86

22d. PHYSICIAN'S NAME (TYPE OR PRINT): PREM LAL, M.D.

22e. ADDRESS: VAMC, Perry Point, Maryland

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 8-30-86

23c. NAME OF CEMETERY OR CREMATORY: Conowingo Baptist

23d. LOCATION — CITY OR TOWN: Conowingo — COUNTY: Cecil — STATE: Md.

24. FUNERAL DIRECTOR: R. T. Foard, Funeral Home — ADDRESS: 111 S. Queen St., Rising Sun, Md. 21911

25a. DATE REC'D. BY REGISTRAR: SEP 8 1986

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Kimball

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

00-14636

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 23057

1. DECEASED NAME (TYPE OR PRINT) FIRST: LILLIAN	MIDDLE: B.	LAST: BUTLER	2a. DATE OF DEATH MONTH DAY YEAR: AUG. 1, 1986	2b. HOUR: M	
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH DAY YEAR: NOV. 13, 1913	6. AGE (IN YEARS LAST BIRTHDAY): 72 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil MD.		
10. CITY OR TOWN OF DEATH: Elkton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Union Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Machine operator	12b. KIND OF BUSINESS OR INDUSTRY: Fibre		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Del.	New Castle	Newark	YES ☒ NO ☐	20 N. Chapel Street 19711

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
John	R.	Walstrum	Naomi	C.	Mitchell

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		222-12-9844	Walter A. Walstrum	308 Vassar Dr., Newark, Del.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute myocardial infarction

DUE TO, OR AS A CONSEQUENCE OF (b): Congestive Heart failure

DUE TO, OR AS A CONSEQUENCE OF (c): Diabetes mellitus

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 8/6/86 19____ to 8/1/86 19____ that (I) (we) last saw the deceased alive on 8/1/86 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 8/4/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Sui Chih Hsu

22e. ADDRESS: 223 West main st. Elkton MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	8/6/86	NEWARK CEM.	NEWARK, NEW CASTLE, DEL.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Robert T. Jones	Newark, Del.	AUG 7 1986	Julia Davidson-Rendell

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

90 15872

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 23058
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR	
WILLIAM	J.	BYRNE	July 30, 1986	9:25am	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Male	White	June 6, 1909	77 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH		
Ontario, Canada	U.S.A.		Cecil MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Perry Point, Md.	VA Medical Center	Unknown	----		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS / ZIP CODE	
Maryland	Baltimore	Baltimore		1412 West Lombard Street 21223	
14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Patrick		Byrne	Mary		Gafney
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS	
yes	WW II	381-09-2903	V.A.M.C. Records,	Perry Point, Maryland. 21902	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Edema of lungs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Pleural effusion, bilateral

DUE TO, OR AS A CONSEQUENCE OF (c) Pericardial effusion

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that ☒ (this hospital) attended the deceased from November 28, 19 84, to July 30, 19 86 that ~~(this hospital)~~ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒	22c. DATE SIGNED
A. Hernandez, MD			7-31-86
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS		
A. HERNANDEZ, M.D.	VA Medical Center, Perry Point, Md.		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE	
Burial	Sept. 1, 1986	Quantico National Cem.	Triangle, Prince William, Virginia	
24. FUNERAL DIRECTOR (SIGNATURE) ADDRESS		25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE	
Patterson & Son Funeral Home, Perryville, Md.		AUG 08 1986	Julia Tinderholt Rudacille	

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

00-16458

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 86 23059

1. DECEASED NAME (TYPE OR PRINT) FIRST: MARY	MIDDLE: C. hristine	LAST: CAMPBELL	2a. DATE OF DEATH MONTH: 8 DAY: 21 YEAR: 86	2b. HOUR: 8 pm M	
3. SEX: female	4. RACE: W	5. DATE OF BIRTH MONTH: 11 DAY: 4 YEAR: 38	6. AGE (IN YEARS LAST BIRTHDAY): 47 YRS	IF UNDER 1 YEAR MONTHS: DAYS:	IF UNDER 24 HRS. HOURS: MIN.:
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): OHIO	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: CECIL MD.		
10. CITY OR TOWN OF DEATH: ELKTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH, FACILITY, GIVE STREET ADDRESS): 72 IRWIN RD.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): AGENT	12b. KIND OF BUSINESS OR INDUSTRY: REAL ESTATE		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MD.	CECIL	ELKTON	YES ☐ NO X	IRWIN RD. 21921

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
CHARLES	CANFIELD	BALZER SR.	AGNES		SMITH

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	17. INFORMANT ADDRESS
NO	198-30-8971	JOSEPH B. CAMPBELL husband- same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARDIOPULMONARY ARREST — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: MINUTES
DUE TO, OR AS A CONSEQUENCE OF (b): PNEUMONIA — DAYS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c): METASTATIC TUMOR CANCER

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: CONGESTIVE SPINA BIFIDA SMOKING

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO X	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
☐ ☐		

21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE
WHILE AT WORK ☐ NOT WHILE AT WORK ☐		

22a. I certify that (I) (this hospital) attended the deceased from 8/30, 19 85, to 8/21, 19 86, that (I) (we) last saw the deceased alive on 8/15, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
	MD ATTENDING PHYSICIAN X MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	8/22/86

22d. PHYSICIAN'S NAME (TYPED OR PRINTED)	22e. ADDRESS
LINWOOD TRUCKS, MD	721 BRIDGE ST, ELKTON, MD 21921

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	AUG. 25, 1986	IMMAC. CONCEP	ELKTON, CECIL, MARYLAND

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
FELLOWS F.H. 226 E. MAIN ST. CECILTON, MD	AUG 27 1986	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

00-17145

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 86 23060

1. DECEASED NAME (TYPE OR PRINT) FIRST: John	MIDDLE: E.	LAST: Cater	2a. DATE OF DEATH MONTH DAY YEAR: 8/31/86	2b. HOUR: 12:10 PM	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: Sept. 10 1918	6. AGE (IN YEARS LAST BIRTHDAY): 67 YRS.	IF UNDER 1 YEAR MONTHS DAYS:	IF UNDER 24 HRS. HOURS MIN.:
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Iowa	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil MD.		
10. CITY OR TOWN OF DEATH: Elkton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Union Hospital of Cecil County	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Realtor	12b. KIND OF BUSINESS OR INDUSTRY		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Delaware	New Castle	Newark	YES ☒ NO ☐	140 Timberline Dr. 19711

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Alfred		Cater	Iva		Johnson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
Yes	Navy, WWII	471 10 4550	Candy Cater, 103 Salem Church Rd. Newark, 19702

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 WEEKS.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: PNEUMONIA.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☒ NO ☐	YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from August 15 19 86 to August 31 19 86, that (I) (we) last saw the deceased alive on August 31 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE		22c. DATE SIGNED
Rahman	MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	9/1/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
EHSANUR RAHMAN	2102 DRUMMOND PLAZA NEWARK, DE. 19711

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Cremation	9/2/86	Hockessin Crematory	Hockessin New Castle De.

24. FUNERAL DIRECTOR	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Hicks Home for Funerals,	Elkton, Md.	SEP 4 1986	Julie Davidson Rundell

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 4, and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16.60M 7/84
(VRA 15, 4)

0-16316

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 023061

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
WALTER	H.	Davis, Jr.	August 23, 1986	5:40 A.M.

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
MALE	WHITE	NOVEMBER 18, 1918	67 YRS		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
MARYLAND	USA		CECIL COUNTY MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Perry Point	PERRY POINT VETERANS MEOICAL CENTER	(RET) SALESMAN	CANOY MANUFACTURING

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MO	HARFORO	HAVRE de GRACE	YES ☒ NO ☐	654 CONGRESS AVENUE 21078

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
WALTER	H.	DAVIS, SR.	HELEN	E.	DOWNEY

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
YES	WW II	219 01 4654	MRS. VIRGINIA WELLS 9575 SPRING BRANCH DR. DALLAS, TX 75238

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (X this hospital) attended the deceased from August 22, 19 86, to August 23, 19 86, that I (we) last saw the deceased alive on August 23, 19 86, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I/we) (did) (did not) view the body after death.

22b. SIGNATURE DEGREE	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED
Michael Delahunt, M.D.		8/23/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
MICHAEL DELAHUNT, M.D.	VA Medical Center, Perry Point, MD 21902

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
BURIAL	26AUGUST86	ANGEL HILL CEMETERY	HAVRE de GRACE, HARFORO CO., MD.

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
MITCHELL FUNERAL HOME, HAVRE DE GRACE, MD. 21078	AUG 26 1986	

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 86 023062

100-16315

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Page 1 copies should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST: George Ralph Devonshire			2a. DATE OF DEATH MONTH DAY YEAR: 8 23 86	2b. HOUR: 9:30 A M
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: 12 03 24	6. AGE (IN YEARS LAST BIRTHDAY): 61 YRS.	IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Md.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil MD.	
10. CITY OR TOWN OF DEATH: Rising Sun	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 36 Colonial Way		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Ret. Electrician	12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Md	Cecil	Rising Sun	YES ☐ NO ☒	36 Colonial Way 21911

14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST	
Delmar E. Devonshire	Edna Hagan	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.
yes	1943-1946	218-18-2628

17. INFORMANT: Geraline G. Devonshire — ADDRESS: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Myocardial Infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO, OR AS A CONSEQUENCE OF (b): Coronary occlusion — Few years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☒ NO ☐	YES ☒ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 2-1, 19 86, to 8-23, 19 86, that (I) (we) last saw the deceased alive on 8-22, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Neil Taylor	MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	8-25-86

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Neil Taylor	Rising Sun, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	8-26-86	Conowingo Baptist	Conowingo Cecil Md.

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
R.T. Foard Funeral Home Rising Sun, Md.	AUG 26 1986	

BP

DHMH - 16 50M 4/82
(VRA 15, 4)

00-16990

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 23063

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. DECEASED NAME (TYPE OR PRINT) FIRST: DUDLEY	MIDDLE: BRADFORD	LAST: DURHAM SR.	2a. DATE OF DEATH MONTH: 8 DAY: 24 YEAR: 86	2b. HOUR: 6 AM
3. SEX: MALE	4. RACE: CAUC.	5. DATE OF BIRTH MONTH: 5 DAY: 3 YEAR: 09	6. AGE (IN YEARS LAST BIRTHDAY): 77 YRS.	IF UNDER 1 YEAR MONTHS / DAYS; IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: CECIL MD.	
10. CITY OR TOWN OF DEATH: ELKTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): UNION HOSPITAL CECIL CO.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): FARMER	12b. KIND OF BUSINESS OR INDUSTRY: FARMING	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
DELAWARE	N. C.	MIDDLETOWN	YES [ ] NO [X]	RX 428 BETHEL-SUMMIT RDG 19709

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
WILLIAM	THOMAS	DURHAM	RACHEL	ELLEN	KANE

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		222-24-0916	FLORENCE W. DURHAM	wife same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute coronary Occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 8 hours

DUE TO, OR AS A CONSEQUENCE OF (b) Coronary artery disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Previous MI ,severe aortic stenosis,Previous episode of CHF.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from Aug, 19 80, to Aug 24, 19 86, that (I (we) last saw the deceased alive on Aug 24, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Wallace Obenshain MD	ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	aug 27 1986

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
DR. WALLACE B. OBENSHAIN	CECIL-KENT HEALTH SERVICES

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	8-26-86	ASBURY CEM.	MILLINGTON KENT MD.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
FELLOWS F. H. 226 E. MAIN ST. CECILTON MD. 21913		

999999

BP

DHMH - 16 50M 4/83
(VRA 15, 4)

0-15101

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 023064

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
WILLIAM	FRANK	EWING	AUGUST 5, 1986	9:15PM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
Male	White	Nov. 10 1912	73 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Mary land	U.S.A.		CecilCounty MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
PERRY POINT, MD	VA MEDICAL CENTER	Truck Driver	Transportation

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Cecil	Elkton	YES ☐ NO ☒	189 Fair Hill Drive 21921

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
FRED	C.	EWING	EMMA		RUSSELL

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
YES	WW II	201-10-8670	F.Russell Ewing,	Blake, Maryland 21921

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) METABOLIC ACIDOSIS

DUE TO, OR AS A CONSEQUENCE OF (b) METHYL ALCOHOL POISONING

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

RENAL FAILURE, ALCOHOLISM

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I/~~this hospital~~) attended the deceased from AUGUST 4, 1986, to AUGUST 5, 1986, that (I/~~we~~) last saw the deceased alive on AUGUST 5, 1986, and that in (my/~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I/~~We~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Glendon E. Rayson	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒	

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
GLENDON RAYSON, M.D.	VA MEDICAL CENTER, PERRY POINT, MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	8/8/86	Sharps Cemetery	Fair Hill Cecil Md.

24. FUNERAL DIRECTOR (NAME) ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Leigh E. Hicks HICKS FUNERAL HOME, ELKTON MD	AUG 12 1986	Julia Davidson-Pindell

10-14354

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 23065
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Amy	Elizabeth	Fagley	8 1 1986	4:30 AM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.
Female	White	9 13 1906	79 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Pa.	U.S.A.		Cecil MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Rising Sun	906 Ridge Road	Housewife	Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD	Cecil	Rising Sun	YES ☐ NO ☒	906 Ridge Rd. 21911

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Franklin		Tyson	Laura	Mae	Hoffecker

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	----	178-034-0990	Joyce Riska	(same as 13 above)

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Carcinoma of liver — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 months

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): Parkinson's disease

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE

22a. I certify that (I) (this hospital) attended the deceased from Jan. 19 86, to 8-1 19 86, that (I) (we) last saw the deceased alive on 7-31 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE				22c. DATE SIGNED
Neil Taylor	MD	ATTENDING PHYSICIAN ☒	MEDICAL DIRECTOR ☐	STAFF PHYSICIAN ☐	8-1-86

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Neil Taylor MD	Rising Sun, Md. 21911

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	8-3-1986	East Coventry Mennonite Cemetery	Pottstown	Chester	Pa.

24. FUNERAL DIRECTOR	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Edward Funeral Home Richard L. Goodie	Rising Sun, Md	AUG 5 1986	Julia Davidson-Mossburg

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/82
(VRA 15, 4)

00-15086

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 023066

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
MARJORIE	MADALINE	FATZ	August 9, 1986	6:00 AM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Female	White	Dec. 22, 1918	67 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. BALTIMORE CITY OR COUNTY OF DEATH
Pennsylvania	USA		Cecil County MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Rising Sun	216 Woody Brown Road	Produce Sales	Agriculture

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Harford	Joppa	YES ☐ NO ☒	304 Pulaski Highway 21085

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Albert	--	Thawley	Madaline	-	Stille

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	--	190-18-1627	Marjorie C. Marll, 1211 Clayton Road, Joppa	Md. 21085

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIAC ARREST

DUE TO, OR AS A CONSEQUENCE OF (b) ARRYTHMIA

DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROTIC Heart Disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

STROKE AND HYPERTENSION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE

22a. I certify that (I) (this hospital) attended the deceased from 8/8 19 86, to 8/9 19 86, that (I) (we) last saw the deceased alive on 8/8 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Dante Monakic MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	8/9/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
DANTE MONAKIC	Bel Air, Md. 21014

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner shall be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	Aug. 12, 1986	Holly Hill Memorial Park,	Baltimore -	Balto-	Md.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Howard K. McComas III,	Abingdon, Md. 21009	AUG 12 1986	Julia Davidson-Randall

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

00-15803

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR: MARIO ROBERT FERNANDEZ

REG. NO. 86 23067

1. DECEASED NAME (TYPE OR PRINT) FIRST: MARIO MIDDLE: ROBERT LAST: FERNANDEZ

2a. DATE OF DEATH MONTH DAY YEAR: August 17, 1986

2b. HOUR: 10:45pm

3. SEX: Male

4. RACE: White

5. DATE OF BIRTH MONTH DAY YEAR: June 11, 1905

6. AGE (IN YEARS LAST BIRTHDAY): 81 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Connecticut

7b. CITIZEN OF WHAT COUNTRY? U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil County MD.

10. CITY OR TOWN OF DEATH: Perry Point, Md.

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): VA Medical Center

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Soldier

12b. KIND OF BUSINESS OR INDUSTRY: Military

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Howard

13c. CITY OR TOWN: Columbia

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE: 5764 Stevens Forest Road 21045

14. FATHER'S NAME FIRST: John MIDDLE: LAST: Fernandez

15. MOTHER'S MAIDEN NAME FIRST: Macrina MIDDLE: LAST: Bari

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes (IF YES, GIVE WAR OR DATES): WW II

16b. SOCIAL SECURITY NO. 051-12-5359

17. INFORMANT: Barbara O'Donnell ADDRESS: 5626 High Tor Hill Columbia, MD. 21045

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardio pulmonary arrest

DUE TO, OR AS A CONSEQUENCE OF (b) Aspiration pneumonia

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Chronic ulcerative gastritis; senile dementia of Alzheimers Disease.

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☒ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (X this hospital) attended the deceased from April 14 19 85 to August 17 19 86 XXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE [signature] DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒

22c. DATE SIGNED: 8-18-86

22d. PHYSICIAN'S NAME: JOHN LONERGAN, M.D.

22e. ADDRESS: VA Medical Center, Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 8/20/86

23c. NAME OF CEMETERY OR CREMATORY: Arlington National

23d. LOCATION CITY OR TOWN: Arlington COUNTY: STATE: Virginia

24. FUNERAL DIRECTOR NAME: Witzke Funeral Home, Catonsville, Md. ADDRESS: 1630 Edmondson Avenue

25a. DATE REC'D. BY REGISTRAR: AUG 20 1986

25b. REGISTRAR'S SIGNATURE: [signature]

BP ______

DHMH - 16 60M 7/84 (VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

00-16554

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

S S 2 3 0 6 8 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ] MONTH	DAY	YEAR	2b. HOUR
Brian	Douglas	Fifield	8/	9/	19 86	M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR	2d. HOUR
Male	White	JUL 26,1965	21 YRS.					8/ 9/ 19 86	2:45 a M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	U.S.A.		Cecil County, MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
NONE	Muddy Lane - 1 mile north Rt. 281	Unemployed	

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET ADDRESS
Maryland	Harford	Havre de Grace		322 Earlton Road,21078

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Daniel	Eugene	Fifield	Ellen	Jean	Baker

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
NO	N/A	214-96-5526	Ellen Mayfield,Same As Above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

8150

IMMEDIATE CAUSE (a) Thermal Injuries

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES [X] NO [ ]

21a. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
	1:38 8/ 9/ 1986	driver of auto/fixed object impact/caught fire

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
	roadway	Muddy Lane-1 mile north	Rt. 281,	Cecil Co.,	Md.

22a I certify that I took charge of the remains described above, held on Autopsy [X], Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ],

ACTUAL SIGNATURE _____ TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER DATE SIGNED 8/9/86

EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D. ADDRESS 111 Penn St.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	8/12/86	Mount Zion Cemetery	Fountain Green,	Harford,	MD

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Tarring Funeral Home,P.A.,Aberdeen,MD,21001-3399	AUG 13 1986	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/B4 25M BP

DHMH - 17 (VR A15 ME (5))

00-17146

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR — 2 — REG. NO. 6 23069

1. DECEASED NAME (TYPE OR PRINT)	FIRST: D.	MIDDLE: ELWOOD	LAST: FORD	2a. DATE OF DEATH MONTH DAY YEAR: AUG. 27, 1986	2b. HOUR: 2:30 P.M.
3. SEX: M	4. RACE: CAUC.	5. DATE OF BIRTH MONTH DAY YEAR: SEPT. 26, 1902	6. AGE (IN YEARS LAST BIRTHDAY): 83 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): DELAWARE	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: CECIL MD.		
10. CITY OR TOWN OF DEATH: ELKTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): UNION HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): FARMER	12b. KIND OF BUSINESS OR INDUSTRY		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
DELAWARE	NEW CASTLE	MIDDLETOWN	YES ☐ NO ☒	269 LOREWOOD GROVE ROAD

14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
FIRST CLARENCE MIDDLE LAST FORD	FIRST ETHEL MIDDLE K. LAST BOGGS	NO (IF YES, GIVE WAR OR DATES)	221-24-9713	BARBARA A. SELBY	R.D.1, BOX 268 MIDDLETOWN, DE 19709

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): acute myocardial infarction

DUE TO, OR AS A CONSEQUENCE OF

(b): arteriosclerotic coronary artery disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 9/12 19 85 to 19 , that (I) (we) last saw the deceased alive on 7/22 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Kenneth Lewis, MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	8/26/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
KENNETH LEWIS	12 PENNINGTON ST, MIDDLETOWN, DE 19709

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	AUG. 31, 1986	ODD FELLOWS	SMYRNA / KENT / DEL.

24. FUNERAL DIRECTOR (NAME)		25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Ralph E. Hicks	Hicks Home for Funerals, Elkton, Md.	SEP 4 1986	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician and completely filled in by the funeral director, page 3 signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/82
(VRA 15, 4)

00-16229

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 86 23070

1. DECEASED NAME (TYPE OR PRINT): FIRST Connie MIDDLE NMI LAST Graybeal

2a. DATE OF DEATH: MONTH 8 DAY 21 YEAR 86

2b. HOUR 11:56 A.M.

3. SEX: FEMALE

4. RACE: WHITE

5. DATE OF BIRTH: MONTH 2 DAY 3 YEAR 1907

6. AGE (IN YEARS LAST BIRTHDAY): 79 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS.: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): N.C.

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil MD.

10. CITY OR TOWN OF DEATH: ELKTON

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): UNION HOSPITAL

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): MACHINE OPERATOR

12b. KIND OF BUSINESS OR INDUSTRY: FACTORY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD

13b. COUNTY: CECIL

13c. CITY OR TOWN: RISING SUN

13d. INSIDE CITY LIMITS? YES [X] NO [ ]

13e. STREET ADDRESS: 150 HOPEWELL RD 21911

14. FATHER'S NAME: FIRST UNKNOWN MIDDLE LAST

15. MOTHER'S MAIDEN NAME: FIRST MINNIE MIDDLE LAST HAMM

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO

(IF YES, GIVE WAR OR DATES):

16b. SOCIAL SECURITY NO.: 220-01-2731

17. INFORMANT: DONALD GRAYBEAL ADDRESS: (SAME ADDRESS)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CARDIORESPIRATORY ARREST — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: MINUTES

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): CARDIOGENIC SHOCK — MINUTES

DUE TO, OR AS A CONSEQUENCE OF (c): ACUTE MYOCARDIAL INFARCTION — DAYS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION: N/A

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES [ ] NO [X]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 11 19 86 to 8/21 19 86, that (I) (we) last saw the deceased alive on 8/21 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE: MD — ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 08/21/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT): LINWOOD BRUCE MD

22e. ADDRESS: 721 BRIDGE STREET, ELKTON MD 21921

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 8-24-86

23c. NAME OF CEMETERY OR CREMATORY: Calvary Baptist

23d. LOCATION: CITY OR TOWN Rising Sun COUNTY Cecil STATE MD

24. FUNERAL DIRECTOR: NAME Hall Funeral Home ADDRESS Richard L. Goodie Rising Sun, Md

25a. DATE REC'D. BY REGISTRAR: AUG 25 1986

25b. REGISTRAR'S SIGNATURE: Lina Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please mail or deliver cover and papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 show any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 4/82
(VRA 15, 4)

00-15081

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified before any action is taken.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 23071

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
EVA	M.	GREGG	AUGUST 5 1986	M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Female	White	May 5 1909	77 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	U.S.A.		Cecil County MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Elkton	Union Hospital of Cecil County	Housewife	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Cecil	Elkton	YES ☒ NO ☐	319 Delancy Road 21921

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
WILLIAM		SCHEAFFER	EVA	M.	CARDIN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No		216 10 6007	Raymond H. Gregg, 319 Delancy Rd., Elkton, Md.

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardio Respiration Arrest

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure

DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Artery Disease

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. **I certify** that (I) (this hospital) attended the deceased from March, 1964, to Aug, 1986, that (I) (we) last saw the deceased alive on Aug 5, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Dr. Joseph G. Lanzi, M.D.	721 Bridge St., Elkton, Maryland, 21921

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	8/9/86	Sharps Cemetery	Fair Hill Cecil Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Hicks Home for Funerals	Elkton, Md.	AUG 12 1986	Julia Davidson-Randall

00-16231

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please complete the remaining copies and forward with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other influences present, the medical examiner must be notified and only

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 23072

1. DECEASED NAME (TYPE OR PRINT) FIRST: John MIDDLE: A. LAST: Heath			2a. DATE OF DEATH MONTH DAY YEAR: Aug. 20, 1986
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: Jan. 19, 1904	6. AGE (IN YEARS LAST BIRTHDAY): 82 YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Elkton, Md.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil MD.
10. CITY OR TOWN OF DEATH: Elkton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Union Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Meat Cutter	12b. KIND OF BUSINESS OR INDUSTRY: Food

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Md.	Cecil	Elkton	YES XX NO ☐	165 Hollingsworth Manor 21921

14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
John Wesley Heath	Anna Marcus

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no		213-05-6128	A Dorothy R. Heath 165 Hollingsworth Manor Elkton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiac Arrest	—
DUE TO, OR AS A CONSEQUENCE OF (b)	Arteriosclerotic Heart Disease	Over 5 yrs.
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☑	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (the hospital) attended the deceased from April 30, 19 86, to Aug 20, 19 86, that (I) (we) last saw the deceased alive on Aug 16, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
[signature]	M.D. ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐	8/21/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
S. Ralph Andrews M.D.	233 E. Main St. Elkton, Md. 21921

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Cremation	8-25-86	R. A. Ferris	West Chester Chester Pa.

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Gee Funeral Home ELKTON, Md.	AUG 25 1986	[signature]

17143

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 86 23073

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST: George W. Heffner				2a. DATE OF DEATH MONTH DAY YEAR: August 30, 1986	2b. HOUR: 3:45 PM P.
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: June 17, 1928	6. AGE (IN YEARS LAST BIRTHDAY): 58 YRS.	IF UNDER 1 YEAR: MONTHS DAYS	IF UNDER 24 HRS: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pa.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil MD.		
10. CITY OR TOWN OF DEATH: Elkton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN EITHER FACILITY, GIVE STREET ADDRESS): Union Hospital		12a. USUAL OCCUPATION (TYPE OF WORK DONE DURING MOST OF WORKING LIFE): Brakemen	12b. KIND OF BUSINESS OR INDUSTRY: Rail Road	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Md.	Cecil	Perryville	YES [ ] NO [X]	200 Carpenters Point Rd. 21903

14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
George Heffner	Janice Yoder

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	Korea	170-22-1263	Grace S. Heffner	200 Carpenters Point Perryville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) metastatic colon cancer — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: months
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from July 19 77 to August 30 19 86 that (I) (we) last saw the deceased alive on August 30 19 86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
Charles M. Hoffman	MD	[ ] [X] [ ]	2 Sept 86

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	9-3-86	Charlestown Cem.	Charlestown Cecil Md.

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Veatch Funeral Home North East, Md.	SEP 4 1986	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. The medical examiner must be notified in some cases.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in some cases.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 23074

1 - FOR STATE REGISTRAR

00-16690

1. DECEASED NAME (TYPE OR PRINT) FIRST: Sara	MIDDLE: B.	LAST: Hubbard	2a. DATE OF DEATH MONTH DAY YEAR: August 26, 1986
2b. HOUR: 11:55 AM			
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: Jan. 2, 1895	6. AGE (IN YEARS LAST BIRTHDAY): 91 YRS.
IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil County MD.
10. CITY OR TOWN OF DEATH: Elkton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Laurelwood Nursing Center	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife	12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Pa.	13b. COUNTY: Delaware	13c. CITY OR TOWN: Drexel Hill	13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS / ZIP CODE: 1204 Morgan Ave. 19026			
14. FATHER'S NAME FIRST: Douglas	MIDDLE: Emerson	LAST: Brinton	15. MOTHER'S MAIDEN NAME FIRST: Hettie MIDDLE: LAST: Hickman
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 168 20 2314	17. INFORMANT ADDRESS: Henry Brinton, 26 W. Union St., West Chester, Pa.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardio Respiratory Arrest
DUE TO, OR AS A CONSEQUENCE OF (b): Pneumonia
DUE TO, OR AS A CONSEQUENCE OF (c): Alzheimer's Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 11/25 19 85 to 8/26 19 86 that (I) (we) last saw the deceased alive on 8/26 19 86 and that (to my) (to our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED:

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Dr. Joseph G. Lanzi, M.D.
22e. ADDRESS: 721 Bridge Street, Elkton, Md. 21921

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 8/29/86	23c. NAME OF CEMETERY OR CREMATORY: Birmingham-Lafayette Birmington Twp.	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Del. Pa.
24. FUNERAL DIRECTOR NAME / ADDRESS: Hicks Home for Funerals, Elton, Md. Ralph E. Hicks	25a. DATE REC'D. BY REGISTRAR: AUG 28 1986	25b. REGISTRAR'S SIGNATURE	

IMPORTANT. If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH - 16 60M 7/84 (VRA 15, 4)

00-15100

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 23075
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH	DAY	YEAR	2b. HOUR
LORRAINE	BLACKBURN	JACOBS	August	4	1986	M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
Female	White	August	14	1950	35 YRS.				

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	U.S.A.		Cecil County MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
North East	106 River Manor Apartments	Clerk	State of Md.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Cecil	North East	YES ☒ NO ☐	106 River Manor Apts. 21901

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Willard	G.	Blackburn	Sylvia		Watson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		219 56 4317	Willard G. Blackburn,	North East, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Cardio Respiratory failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 hrs

DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Thymoma. — 2 Years

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 8/13/85 to 8/1/86 that (I) (~~saw~~) last saw the deceased alive on 7/11/86 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~saw~~) (~~did~~) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED
William.	MD		8/5/86.

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
KAMRUDIN MITHANI	131 S. UNION AVE. HAVRE DE GRACE MD 21078.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	8/6/86	Asbury Methodist Cemetery	Port Deposit, Cecil Md.

24. FUNERAL DIRECTOR (NAME)	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Hicks Home for Funerals	Elkton, Maryland	AUG 12 1986	Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

00-14683

1 - FOR STATE REGISTRAR item 13a 13b 13c 13e film g619 9-8-86 I.J

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 23076
REG. NO.

Field	Entry
1. DECEASED NAME (TYPE OR PRINT) — FIRST / MIDDLE / LAST	RICHARD W. KELLEY
2a. DATE OF DEATH — MONTH DAY YEAR	August 6, 1986
2b. HOUR	8:20am
3. SEX	Male
4. RACE	White
5. DATE OF BIRTH — MONTH DAY YEAR	December 26, 1925
6. AGE (IN YEARS LAST BIRTHDAY)	60 yrs. YRS.
IF UNDER 1 YEAR — MONTHS / DAYS	
IF UNDER 24 HRS — HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Pennsylvania
7b. CITIZEN OF WHAT COUNTRY?	U.S.A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	NEVER MARRIED XX
9. BALTIMORE CITY OR COUNTY OF DEATH	Cecil County MD.
10. CITY OR TOWN OF DEATH	Perry Point, Md.
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	VA Medical Center
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Laborer
12b. KIND OF BUSINESS OR INDUSTRY	----------
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION)	
13a. STATE	~~Pennsylvania~~ Maryland
13b. COUNTY	~~Lackawanna~~ Montgomery
13c. CITY OR TOWN	~~Scranton~~ Chevy Chase
13d. INSIDE CITY LIMITS?	YES XX NO ☐
13e. STREET ADDRESS / ZIP CODE	6618 Hillandale Rd. ~~99999~~ 21992
14. FATHER'S NAME — FIRST / MIDDLE / LAST	Ralph W. Kelley
15. MOTHER'S MAIDEN NAME — FIRST / MIDDLE / LAST	Kathryn Richards
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	Yes
(IF YES, GIVE WAR OR DATES)	1943-1946
16b. SOCIAL SECURITY NO.	094-16-9554
17. INFORMANT — ADDRESS	V.A.M.C., Medical Records, Perry Point, Md.

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Aspiration of gastric contents	
DUE TO, OR AS A CONSEQUENCE OF (b)	Emphysema of lungs, severe	
DUE TO, OR AS A CONSEQUENCE OF (c)	Fibrous pleural adhesions, bilateral	

911

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Field	Entry
19a. DATE OF OPERATION	
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY?	YES XX NO ☐
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION — STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that X (this hospital) attended the deceased from August 25, 1982 to August 6, 1986 XXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I (we) (did) (did not) view the body after death.

Field	Entry
22b. SIGNATURE	[signature] J. R. Garcia
DEGREE	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN X
22c. DATE SIGNED	8-6-86
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	J. R. GARCIA, M.D.
22e. ADDRESS	VA Medical Center, Perry Point, Md.
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	Burial
23b. DATE	Aug. 11, 1986
23c. NAME OF CEMETERY OR CREMATORY	Wyoming Cemetery
23d. LOCATION — CITY OR TOWN / COUNTY / STATE	Wyoming Luzerne Pennsylvania
24. FUNERAL DIRECTOR	Patterson & Son, Perryville, Md. FOR: Snowden Funeral Home, Scranton, Pa.
25a. DATE REC'D. BY REGISTRAR	AUG 7 1986
25b. REGISTRAR'S SIGNATURE	[signature]

999999

BP

DHMH - 16 60M 7/84 (VRA 15, 4

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

0216268

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1- FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

389 23077 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Kimberly	MIDDLE	LAST: Kelly	2a. DATE OF DEATH KNOWN XX / ESTIMATED ☐ MONTH: 8-22	DAY	YEAR: 19 86	2b. HOUR	M
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH: Aug. DAY: 26, YEAR: 1967	6. AGE (IN YEARS LAST BIRTHDAY) YRS.: 18	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.	2c. DATE PRONOUNCED DEAD MONTH: 8-22 DAY / YEAR: 19 86	2d. HOUR 12:04 a.m.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil County, MD.				
10. CITY OR TOWN OF DEATH: Elkton	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Union Hospital of Cecil County	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Student	12b. KIND OF BUSINESS OR INDUSTRY				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Pennsylvania	13b. COUNTY: Delaware	13c. CITY OR TOWN: Ridley Park	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS: 423 Stiles Avenue 19078			
14. FATHER'S NAME FIRST: John	MIDDLE: Kelly	LAST	15. MOTHER'S MAIDEN NAME FIRST: Janet	MIDDLE: Hazel	LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES): -------	16b. SOCIAL SECURITY NO.: 195-58-9449	17. INFORMANT: Mrs. Janet Kelly	19078	423 Stiles Avenue Ridley Park, PA		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1 DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Blunt trauma to Chest and Abdomen — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

8150

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES XX NO ☐
21a. EXTERNAL CAUSE WAS UNDERLYING XX OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR: 10:10PM MONTH DAY YEAR: 8-21 19 86	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): driver in auto/fixed object impact	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK XX	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): road	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE: Bouchelle Rd. north of RR bridge, Cecil Co., Md.	

22a. I certify that I took charge of the remains described above, held an Autopsy XX, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident XX, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Dennis Smyth M.D. TITLE (SPECIFY): M.D. Assistant MEDICAL EXAMINER DATE SIGNED: 8-22-86

EXAMINER'S NAME (TYPE OR PRINT): Dennis F. Smyth, M.D. ADDRESS: 111 Penn St., Balto., Md. 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 8/26/86	23c. NAME OF CEMETERY OR CREMATORY: Sudlersville Cemetery	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Sudlersville, Kent Maryland	
24. FUNERAL DIRECTOR NAME: Loring Byers Funeral Directors, Inc. ADDRESS: 8728 Liberty Road Randallstown, MD. 21133		25a. DATE REC'D. BY REGISTRAR: AUG 26 1986	25b. REGISTRAR'S SIGNATURE: [signature]	

DHMH - 17 (VR A15 ME (5))

00-16688

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 23078

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, [illegible] and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner, rather than the attending physician, must complete this certificate.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: Naomi	MIDDLE: K.	LAST: Kohl	2a. DATE OF DEATH MONTH DAY YEAR: 8/25/86	2b. HOUR: 708 A M.
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: Dec. 31 1906	6. AGE (IN YEARS LAST BIRTHDAY): 79 YRS.	UNDER 1 YEAR: MONTHS / DAYS; UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil Co MD.	
10. CITY OR TOWN OF DEATH: Elkton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Union Hospital of Cecil County	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife	12b. KIND OF BUSINESS OR INDUSTRY	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland	13b. COUNTY: Cecil	13c. CITY OR TOWN: North East	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS / ZIP CODE: 107 Lakeside Drive 21901

14. FATHER'S NAME FIRST / MIDDLE / LAST: Samuel Westley		15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST: Katie Tothero	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 170 05 6388	17. INFORMANT ADDRESS: Delores M. Kohl, 107 Lakeside Dr., N.E., Md. 21901

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiac arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 hour

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Acute myocardial infarction

DUE TO, OR AS A CONSEQUENCE OF (c): Arteriosclerotic heart disease

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Diabetes Mellitus, Hypertension

19a. DATE OF OPERATION: 8/23/86	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Incarcerated Umbilical Hernia	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that I (this hospital) attended the deceased from 8/21, 19 86, to 8/25, 19 86, that I (we) last saw the deceased alive on 8/25, 19 86, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Edgar E. Folk III	DEGREE: M.D. ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒	22c. DATE SIGNED: 8/25/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT): EDGAR E FOLK III MD	22e. ADDRESS: ELKTON Md 21921	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 8/28/86	23c. NAME OF CEMETERY OR CREMATORY: St. Johns Cemetery	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Roberson Township, Berks Co., Pa.	
24. FUNERAL DIRECTOR NAME / ADDRESS: Ralph E. Hicks, Hicks Home for Funerals, Elkton, Md.		25a. DATE REC'D. BY REGISTRAR: AUG 28 1986	25b. REGISTRAR'S SIGNATURE: [illegible]	

00-16689

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 23079

1. DECEASED NAME (TYPE OR PRINT) FIRST: Helen	MIDDLE: J.	LAST: LAKE	2a. DATE OF DEATH MONTH DAY YEAR: 8/24/86		2b. HOUR: 1500 M
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: March 6 1910	6. AGE (IN YEARS LAST BIRTHDAY): 76 YRS.	UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MINS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil Co		MD.
10. CITY OR TOWN OF DEATH: Elkton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Union Hospital of Cecil County		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): housewife		12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Cecil	Elkton	YES ☐ NO ☒	671 Leeds Road, 21921

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Samuel	W.	Wilson	Mary	J.	Ashworth

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		218 05 4689	Mrs.Audrey Natale,1507 Stoney Run Dr.	Wilm.,De.,19803

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) RESPIRATORY FAILURE — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) EMPHYSEMA +

DUE TO, OR AS A CONSEQUENCE OF (c) NON HODGKINS LYMPHOMA

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 9/84, 19____, to 8/24, 19 86, that (I (we) last saw the deceased alive on 8/24, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN ☒ / MEDICAL DIRECTOR ☐ / STAFF PHYSICIAN ☐	22c. DATE SIGNED
Gary Beste	M.D		8/25/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
GARY Beste M.D	Newark Del

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	8/28/86	Union Cemetery	Union / Cecil / Md.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Joseph E. Hicks Hicks Home for Funerals	Elkton, Md.	AUG 28 1986	

00-15217

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 6 23080

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4, which should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and may require autopsy.

1. DECEASED NAME (TYPE OR PRINT) FIRST: ELLSWORTH	MIDDLE: LINDSEY	LAST: LEE, SR	2a. DATE OF DEATH MONTH DAY YEAR: AUGUST 11, 1986	2b. HOUR: 8:55P M	
3. SEX: Male	4. RACE: Black	5. DATE OF BIRTH MONTH DAY YEAR: Feb. 26 1916	6. AGE (IN YEARS LAST BIRTHDAY): 70 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil County MD.		
10. CITY OR TOWN OF DEATH: PERRY POINT, MD	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): VA MEDICAL CENTER	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Foreman	12b. KIND OF BUSINESS OR INDUSTRY: Railroad-Ret.		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Harford	13c. CITY OR TOWN: Abingdon	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS / ZIP CODE: 3624 B&O Road 21009	
14. FATHER'S NAME FIRST: Edward	MIDDLE: --	LAST: Lee	15. MOTHER'S MAIDEN NAME FIRST: Bertha	MIDDLE: --	LAST: Parker
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes	(IF YES, GIVE WAR OR DATES): WWII	16b. SOCIAL SECURITY NO.: 717-07-5566	17. INFORMANT: Deborah Lee, 226 Brunswick Place, Newport News	ADDRESS: Va. 23601	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARIO PULMONARY ARREST
DUE TO, OR AS A CONSEQUENCE OF
(b): SEPTICEMIA
DUE TO, OR AS A CONSEQUENCE OF
(c): METASTATIC LUNG CANCER
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from JULY 17, 19 86, to AUGUST 11, 19 86 that (I) (we) last saw the deceased alive on AUGUST 11, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Paul Siddoway MD — DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒ — 22c. DATE SIGNED: 8/11/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT): PAUL SIDDOWAY, M.D.

22e. ADDRESS: VA MEDICAL CENTER, PERRY POINT, MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: Aug. 16, 1986	23c. NAME OF CEMETERY OR CREMATORY: John Wesley U.M. Cemetery	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Abingdon Harford Md.
24. FUNERAL DIRECTOR (NAME): Howard K. III	ADDRESS: McComas Funeral Home, Abingdon, Md. 21009	25a. DATE REC'D. BY REGISTRAR: AUG 14 1986	25b. REGISTRAR'S SIGNATURE

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

#1822a, FilmG618 8/15/86 kam

00-12986

1- FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 23081

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH KNOWN ☐ ESTIMATED ☒ MONTH	DAY	YEAR	2b. HOUR
EDWARD	E.	MERKEL	7	11	1986	M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR	2d. HOUR
M	White	11-09-1914	71 YRS.			7 13 1986	8:45 PM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland	USA		Cecil County MD				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY				
Perryville	Perryville Park near Washington Pt.	Painter	Private				

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS
Md.	Prince George	Bowie		9439 Merkel Rd. 20715

14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST	
Ernst	Merkel	Frieda Schuman

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
yes	WWII	578-20-0377	Ann Plekanec	9435 Merkel Rd. Bowie 20715

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE [signature] TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER DATE SIGNED 7-15-86

EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. ADDRESS 111 Penn St., Balto., MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	7/17/86	First Lutheran Church Cemetery	Bowie Prince George Md

24. FUNERAL DIRECTOR	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Donald Borgwardt 4400 Powder Mill Rd. Beltsville Md 20705	JUL 21 1986	Julia Davidson Henderson

07/84 25M BP224

DHMH - 17 (VR A15 ME (5))

00-16805

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 06 23082

1. DECEASED NAME (TYPE OR PRINT) First: Edgar; Middle: C.; Last: Miller				2a. DATE OF DEATH Month Day Year: Aug 26, 1986	2b. HOUR: 715 PM
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH Month Day Year: July 25 1902	6. AGE (If Years Last Birthday): 84 YRS.	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.
7a. BIRTHPLACE (State or Foreign Country): Pa.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil MD.		
10. CITY OR TOWN OF DEATH: Elkton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (If not in such facility, give street address): Laurelwood Nursing Center	12a. USUAL OCCUPATION (Type of work for most of working life): Self-employed	12b. KIND OF BUSINESS OR INDUSTRY: Farmer		

USUAL RESIDENCE (If nursing home or other institution, give residence before admission)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Md.	Cecil	North East	YES [ ] NO [X]	1704 Turkey Point Rd. 21901

14. FATHER'S NAME First / Middle / Last	15. MOTHER'S MAIDEN NAME First / Middle / Last
Martin Miller	Edith Lawrence

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Specify Yes, No or Unknown)	(If Yes, give war or dates)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
No		219-10 8719	Ruth Alexander North East, Md. 21901	1704 Turkey Point Rd.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Chronic Obstructive Lung Disease — Approximate Interval Between Onset and Death: Months-4 hours, Years-60

DUE TO, OR AS A CONSEQUENCE OF (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Cancer of Prostate, Anemia

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Item 18, Part I or Part 2)
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (At home, street, factory, office, farm, etc.)	21f. LOCATION Street / City or Town / County / State

22a. I certify that (I) (this hospital) attended the deceased from July 19 79 to August 26 19 86, that (I) (we) last saw the deceased alive on August 25 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Charles M. Hinojosa	MD — Attending Physician [X] Medical Director [ ] Staff Physician [ ]	26 Aug 86

22d. PHYSICIAN'S NAME (Type or Print)	22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION City or Town / County / State
Burial	8-30-86	St. John's Epis.	West Caln Township Chester Pa.

24. FUNERAL DIRECTOR Name / Address	25. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Robert T. Casey North East, Md.	AUG 29 1986	Jane Anderson-Registrar

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

1 GR. 1
00-15956

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

88 23083 REG. NO.

1. DECEASED NAME (TYPE OR PRINT): FIRST John MIDDLE E. LAST Patrizi

2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] MONTH 8 DAY 7 YEAR 1986 — 2b. HOUR

3. SEX: Male — 4. RACE: White — 5. DATE OF BIRTH: March 20, 1938 — 6. AGE (IN YEARS LAST BIRTHDAY): 48 YRS. — IF UNDER 1 YR. MONTHS DAYS — IF UNDER 24 HRS. HOURS MIN.

2c. DATE PRONOUNCED DEAD: MONTH 8 DAY 7 YEAR 1986 — 2d. HOUR 7:20 P M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Ohio — 7b. CITIZEN OF WHAT COUNTRY?: U. S. A. — 8. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [X] — 9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil County MD.

10. CITY OR TOWN OF DEATH: Elkton — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Union Hosp. of Cecil Co. — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Dry WallInstaller — 12b. KIND OF BUSINESS OR INDUSTRY: Bldg. Trade

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland — 13b. COUNTY: Cecil — 13c. CITY OR TOWN: Elkton — 13d. INSIDE CITY LIMITS? YES [ ] NO [X] — 13e. STREET ADDRESS: P. O. Box 1332 21921

14. FATHER'S NAME: FIRST William MIDDLE Francis LAST Patrizi

15. MOTHER'S MAIDEN NAME: FIRST Mildred MIDDLE LAST Roberts

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): Yes — (IF YES, GIVE WAR OR DATES): Air Force, WWII — 16b. SOCIAL SECURITY NO.: 262 54 1795 — 17. INFORMANT ADDRESS: Mildred P. Mora, P. O. Box 133, Cortez, Florida 33522

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Atherosclerotic heart disease
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Arterial hypertension

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES [ ] NO [ ]

21a. EXTERNAL CAUSE WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [ ], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ].

ACTUAL SIGNATURE [signature] M.D. TITLE (SPECIFY) Deputy MEDICAL EXAMINER — DATE SIGNED 8/7/86

EXAMINER'S NAME (TYPE OR PRINT) Juan C Gonzalez-Vital MD ADDRESS Union Hosp. Elkton MD 21921

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation — 23b. DATE 8/13/86 — 23c. NAME OF CEMETERY OR CREMATORY: R. A. Ferris Company — 23d. LOCATION CITY OR TOWN: West Chester COUNTY: Chester STATE: Pa.

24. FUNERAL DIRECTOR NAME: Hicks Home for Funerals — Elkton, Md.

25a. DATE REC'D. BY REGISTRAR: AUG 20 1986 — 25b. REGISTRAR'S SIGNATURE: [signature]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM DH 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 86 23084

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be mailed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT. If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	WILLIAM	FRANCIS	POWERS	2a. DATE OF DEATH MONTH DAY YEAR	August 26, 1986	2b. HOUR: 6:16am
3. SEX	Male					
4. RACE	White					
5. DATE OF BIRTH MONTH DAY YEAR	6 15 1927					
6. AGE (IN YEARS LAST BIRTHDAY)	59 YRS	IF UNDER 1 YEAR: MONTHS / DAYS		IF UNDER 24 HRS: HOURS / MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	New York					
7b. CITIZEN OF WHAT COUNTRY?	U.S.A.					
8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐						
9. BALTIMORE CITY OR COUNTY OF DEATH	Cecil County MD.					
10. CITY OR TOWN OF DEATH	Perry Point, Md.					
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	VA Medical Center					
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Steel Worker					
12b. KIND OF BUSINESS OR INDUSTRY	Beth. Steel					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	Maryland					
13b. COUNTY	Baltimore					
13c. CITY OR TOWN	Dundalk					
13d. INSIDE CITY LIMITS? YES ☐ NO ☒						
13e. STREET ADDRESS / ZIP CODE	825 Jaydee Avenue 21222					
14. FATHER'S NAME FIRST / MIDDLE / LAST	Frank		Powers			
15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	Anna		Lauer			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	Yes					
(IF YES, GIVE WAR OR DATES)	WW II					
16b. SOCIAL SECURITY NO.	219-22-8332					
17. INFORMANT	Hazel W. Powers			ADDRESS	Same as 13e	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardio vascular disease
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Squamous cell carcinoma of lung; diabetes mellitus

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that X (this hospital) attended the deceased from May 31, 19 85, to August 26, 19 86, that X (we) last saw the deceased alive on August 26, 19 86, and that in XX (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE Glendon Rayson DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒ — 22c. DATE SIGNED 8-26-86

22d. PHYSICIAN'S NAME (TYPE OR PRINT) GLENDON RAYSON, M.D. — 22e. ADDRESS VA Medical Center, Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE	
Burial	8/28/1986	Gardens Of Faith	Baltimore	Maryland
24. FUNERAL DIRECTOR (NAME)	Duda-Ruck Funeral Home, Baltimore, Md.	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE	
		AUG 29 1986		

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

00-15332

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 6 23085

1. DECEASED NAME (TYPE OR PRINT) FIRST: GRANT	MIDDLE: William	LAST: Prewitt	2a. DATE OF DEATH MONTH: August	DAY: 7	YEAR: 1986
2b. HOUR: 4:30 P M					
3. SEX: M	4. RACE: White	5. DATE OF BIRTH MONTH: 1-29-	DAY:	YEAR: 1939	
6. AGE (IN YEARS LAST BIRTHDAY): 47 YRS.	IF UNDER 1 YEAR MONTHS:	DAYS:	IF UNDER 24 HRS HOURS:	MIN:	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): PENNA	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil MD.		
10. CITY OR TOWN OF DEATH: Rising Sun	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 601 Telegraph Rd	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Business Mgr	12b. KIND OF BUSINESS OR INDUSTRY		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY, OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Md	Cecil	Rising Sun	YES [ ] NO [X]	601 Telegraph Rd 21911

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
GRANT	H.	Prewitt	ROSA	Belle	FULTON

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		172-30-1617	Barbara Prewitt	Rising Sun Md 21911

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for a, b, and c.)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Metastatic lung cancer — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Months

DUE TO, OR AS A CONSEQUENCE OF (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE

22a. **I certify** that (I) (this hospital) attended the deceased from 5/27 19 86 to 7/7 19 86 that (I) (we) last saw the deceased alive on 7/7 19 86 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (Am) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
John Mann M.D.	ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	8/6/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
MANN JOHN J	611 PARK AVE BALT MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	8/6/86	Oxford Cemetery	Oxford	Chester	Pa.

24. FUNERAL DIRECTOR (NAME)	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
RT Pond	Rising Sun, Md.	AUG 13 1986	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other trauma, the medical examiner must be notified at once.

BP_____

DMMH - 16 50M 1/76
(VR A 15 (4))

00-14813

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and use Items 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP____

DHMH - 16 50M 4/82
(VRA 15, 4)

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 23086

1. DECEASED NAME (TYPE OR PRINT) FIRST: GRANVILLE MIDDLE: S LAST: PRYOR		2a. DATE OF DEATH MONTH DAY YEAR: 8-3-86	2b. HOUR: M
3. SEX: M	4. RACE: W	5. DATE OF BIRTH MONTH DAY YEAR: 5 10 29	6. AGE (IN YEARS LAST BIRTHDAY): 57 YRS; IF UNDER 1 YEAR MONTHS DAYS; IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): De	7b. CITIZEN OF WHAT COUNTRY?: U.S.A	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: CECIL MD.
10. CITY OR TOWN OF DEATH: ELKTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): UNION HOSP.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): ELECTRICIAN	12b. KIND OF BUSINESS OR INDUSTRY: CONST
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD	13b. COUNTY: CECIL	13c. CITY OR TOWN: CHESAPEAKE CITY	13d. INSIDE CITY LIMITS? YES [ ] NO [X]
13e. STREET ADDRESS: 32 RIVER RD			
14. FATHER'S NAME FIRST: GRANVILLE MIDDLE: S LAST: PRYOR		15. MOTHER'S MAIDEN NAME FIRST: MARJORIE MIDDLE: M LAST: HALL	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 169-20-8258	17. INFORMANT: VERBA PRYOR	ADDRESS: CHESAPEAKE CITY MD

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiovascular Collapse — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Minutes

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): ~~Malena~~ GI bleeding and Liver/Renal Failure — Days

DUE TO, OR AS A CONSEQUENCE OF (c): Metastatic Renal cell carcinoma — Weeks

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Diabetes Mellitus

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from ____ 19____ to ____ 19____ that (I) (we) last saw the deceased alive on ____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: R Denitzio	DEGREE: M.D. ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ]	22c. DATE SIGNED: 8/7/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Robert Denitzio, M.D.	22e. ADDRESS: Cecilton, Md. 21913		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE: 8-7-86	23c. NAME OF CEMETERY OR CREMATORY: SILVER BROOK	23d. LOCATION CITY OR TOWN: WILMINGTON	COUNTY: DE STATE
24. FUNERAL DIRECTOR NAME: Robert J. Ford ADDRESS: Chesapeake	25a. DATE REC'D. BY REGISTRAR: AUG 8 1986	25b. REGISTRAR'S SIGNATURE: Edna Davidson-Randall		

FUNERAL DIRECTOR: ST. FORD FUNERAL HOME CITY

00-16066

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 6 23081

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonskippers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified before burial.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST: Nellie M. Ross				2a. DATE OF DEATH MONTH DAY YEAR: 8 19 86	2b. HOUR: 0130 M
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH DAY YEAR: JUNE 12, 1896	6. AGE (IN YEARS LAST BIRTHDAY): 90 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil COUNTY MD.		
10. CITY OR TOWN OF DEATH: ELKTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): UNION HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOMEMAKER	12b. KIND OF BUSINESS OR INDUSTRY:	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD	13b. COUNTY: HARFORD	13c. CITY OR TOWN: HAVRE de GRACE	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS / ZIP CODE: 704 LAFAYETTE STREET 21078	
14. FATHER'S NAME FIRST / MIDDLE / LAST: CHARLES W. MITCHELL			15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST: OLEITA HORTON		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.: 218 52 1354	17. INFORMANT: JAMES MITCHELL	ADDRESS: SAME AS #13e	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CARDIORESPIRATORY ARREST	MINUTES
DUE TO, OR AS A CONSEQUENCE OF (b)	RESPIRATORY FAILURE	DAYS
DUE TO, OR AS A CONSEQUENCE OF (c)	ASPIRATION PNEUMONIA & CONGESTIVE HEART FAILURE	DAYS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): DEMENTIA, SENILE MYOCARDIAL INFARCTION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that I (this hospital) attended the deceased from 7 19 86 to 8 18 19 86 that I (we) last saw the deceased alive on 8/18 19 86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c. DATE SIGNED: 8/19/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT): MINOO BRUCE, MD 22e. ADDRESS: 721 BRUCE ST., ELKTON, MD 21921

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	22 AUGUST 86	ANGEL HILL CEMETERY	HAVRE de GRACE, HARFORD CO., MD.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
MITCHELL FUNERAL HOME PA HAVRE de GRACE, MD. 21078	AUG 21 1986	Lidia Davidson-Kindle

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal from the state. If medical examiner is notified, please so state.

IMPORTANT: If item 21 is marked or there is known any injury, or other traumatic event, the medical examiner must be notified before disposition.

BP____

DHMH - 16 60M 7/84
(VRA 15, 4)

20-15324

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 23088

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST: Alberto Saenz				2a. DATE OF DEATH MONTH DAY YEAR: August 11, 1986	2b. HOUR: 3:45A M
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: May 12, 1921	6. AGE (IN YEARS LAST BIRTHDAY): 65 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Texas	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil Co. MD.		
10. CITY OR TOWN OF DEATH: Perry Point, Md.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): VA Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Carpenter	12b. KIND OF BUSINESS OR INDUSTRY: GSA	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md.	13b. COUNTY: AACo	13c. CITY OR TOWN: Edgewater	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET ADDRESS / ZIP CODE: 1223 Pine Ave. 21037	
14. FATHER'S NAME FIRST / MIDDLE / LAST: Juan Saenz			15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST: Julia Agu		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes	(IF YES, GIVE WAR OR DATES): WWII	16b. SOCIAL SECURITY NO.: 452 26 5113	17. INFORMANT ADDRESS: VAMC, Perry Point, Maryland		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiac arrest

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Diabetes Mellitus

DUE TO, OR AS A CONSEQUENCE OF (c): Arteriosclerotic cardic vascular disease

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (this hospital) attended the deceased from 6-2- 19 86 to 8-11- 19 86 that (we) last saw the deceased alive on 8-11- 19 86 and that in (our) opinion death occurred on the date and hour and from the causes stated above, ([X] we) (did) (did not) view the body after death.

22b. SIGNATURE: Michael Delahunt M.D.	DEGREE: ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [X]	22c. DATE SIGNED: 8-11-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT): MICHAEL V. DELAHUNT, M.D.	22e. ADDRESS: VAMC, Perry Point, Maryland		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 8-14-86	23c. NAME OF CEMETERY OR CREMATORY: Md. Veterans Cem.	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Crownsville AACo. Md.
24. FUNERAL DIRECTOR NAME / ADDRESS: Hardesty Funeral Home, Annapolis, Md.	25a. DATE REC'D. BY REGISTRAR: AUG 13 1986	25b. REGISTRAR'S SIGNATURE	

00-15387

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 23089

1. DECEASED NAME (TYPE OR PRINT) First / Middle / Last: Virginia A. Shepherd				2a. DATE OF DEATH Month / Day / Year: August 10, 1986	2b. HOUR: 1435 M
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH Month / Day / Year: April 2, 1911		6. AGE (IN YEARS LAST BIRTHDAY): 75 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): W. Va.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐		9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil MD.	
10. CITY OR TOWN OF DEATH: Elkton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Union Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Super.	12b. KIND OF BUSINESS OR INDUSTRY: DuPont Co.
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md.	13b. COUNTY: Cecil	13c. CITY OR TOWN: North East	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS / ZIP CODE: 115 Wallace Ave. 21901	
14. FATHER'S NAME First / Middle / Last: William Floyd Shepherd		15. MOTHER'S MAIDEN NAME First / Middle / Last: Sarah Lucille Hayes			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 212-12-3418	17. INFORMANT: James E. Shepherd	ADDRESS: P.O. Box 193 North East, Md. 219		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute myocardial infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: hours
DUE TO, OR AS A CONSEQUENCE OF
(b): Hypertension
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Rheumatoid arthritis contractions

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from July, 19 79, to August 10, 19 86, that (I) (we) last saw the deceased alive on February 15, 19 86, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Charles M. Hughes	DEGREE: MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 11 Aug 86
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 8-13-1986	23c. NAME OF CEMETERY OR CREMATORY: North East Methodist	23d. LOCATION CITY OR TOWN: North East	COUNTY: Cecil STATE: Md.
24. FUNERAL DIRECTOR NAME: Couch Funeral Home	ADDRESS: North East, Md	25a. DATE REC'D. BY REGISTRAR: AUG 13 1986	25b. REGISTRAR'S SIGNATURE: Gina Davidson	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or medical examiner, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

0-16491

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner or the coroner of the county in which death occurred must be notified before any action is taken.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 23090

1. DECEASED NAME (TYPE OR PRINT) FIRST: John	MIDDLE: Frederick	LAST: Shine	2a. DATE OF DEATH MONTH DAY YEAR: August 25, 1986	2b. HOUR: 4:50P M	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: 12 12 1899	6. AGE (IN YEARS LAST BIRTHDAY): 86 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil County MD.		
10. CITY OR TOWN OF DEATH: Perry Point	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Perry Point Va. Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Pipe Fitter Sup.	12b. KIND OF BUSINESS OR INDUSTRY: U.S. Coast Guard Yard		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland		Baltimore	YES ☒ NO ☐	1817 Swansea Rd. 21239

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
August / Shine	Minnie / Walksmuth

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
YES	WW I	215 09 1187	John F. Shine, Jr. 1817 Swansea Rd. 21239

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiac arrest

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Chronic pneumonia

DUE TO, OR AS A CONSEQUENCE OF (c): Alzheimers dementia

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that X (this hospital) attended the deceased from October 29, 19 85, to August 25, 19 86, that (X (we) last saw the deceased alive on August 25, 19 86, and that in (XXX our) opinion death occurred at the date and hour and from the causes stated above. (I (we) did) XXXX view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Glendon Rayson	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐	8/25/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
GLENDON RAYSON, M.D.	VA Medical Center, Perry Point, MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	8/29/86	Loudon park Cemetery	Baltimore Maryland

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
HUBBARD FUNERAL HOME, 4107 Wilkens Avenue BALTIMORE, MD. 21229	AUG 27 1986	June Lourdon-Registrar

00-15955

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO. 23091

1. DECEASED NAME (TYPE OR PRINT): FIRST Dorothy MIDDLE S. LAST Shull

2a. DATE OF DEATH: KNOWN X ESTIMATED ☐ MONTH 8 DAY 16 YEAR 1986 — 2b. HOUR

3. SEX: Female — 4. RACE: White — 5. DATE OF BIRTH: MONTH 10 DAY 20 YEAR 19 — 6. AGE (IN YEARS LAST BIRTHDAY): 66 YRS. — IF UNDER 1 YR. MONTHS DAYS — IF UNDER 24 HRS. HOURS MIN

2c. DATE PRONOUNCED DEAD: MONTH 8 DAY 16 YEAR 1986 — 2d. HOUR 2:20 P M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania

7b. CITIZEN OF WHAT COUNTRY? U. S. A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED X

9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil County MD.

10. CITY OR TOWN OF DEATH: Fredericktown

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Foot of George Street

12a. USUAL OCCUPATION (TYPE OF WORK EOR MOST OF WORKING LIFE): Food Service Handler

12b. KIND OF BUSINESS OR INDUSTRY: Insurance

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Pa. — 13b. COUNTY: Montgomery — 13c. CITY OR TOWN: Phila. — 13d. INSIDE CITY LIMITS? YES X NO ☐ — 13e. STREET ADDRESS: 244 River Road, Gladwyne, Pa. 19035

14. FATHER'S NAME: FIRST William MIDDLE LAST Scott

15. MOTHER'S MAIDEN NAME: FIRST Elizabeth MIDDLE LAST Hall

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 201-05-5579

17. INFORMANT: Byrne Funeral Home, ADDRESS: 2315 Cumberland St Phila. Pa. 19125

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Atherosclerotic heart disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES ☐ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection X, Inquiry ☐, and in my opinion death resulted from: Noturol causes X, Accident ☐, Suicide ☐, Homicide ☐, Undetermined monner ☐.

ACTUAL SIGNATURE [signature] M.D. TITLE (SPECIFY) Deputy MEDICAL EXAMINER — DATE SIGNED 8-16-86

EXAMINER'S NAME (TYPE OR PRINT) Ivan C Gonzalez-Vitali MD ADDRESS Union Hosp. Elkton, MD 21921

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation — 23b. DATE: 8/22/86 — 23c. NAME OF CEMETERY OR CREMATORY: West Laural Hill Crematory — 23d. LOCATION CITY OR TOWN Bala Cynwyd COUNTY Mont. STATE Pa.

24. FUNERAL DIRECTOR NAME (LICENSE NO.) Hicks Home for Funerals, Elkton, Md. — 25a. DATE REC'D. BY REGISTRAR: AUG 20 1986 — 25b. REGISTRAR'S SIGNATURE [signature]

DHMH - 17
(VR A15 ME (5))
20M 4/82

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 72 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL UNDER ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PAM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

00-15548

1- FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 23092

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) — FIRST / MIDDLE / LAST	Monroe ~~Studebaker~~	Erving	Studebaker	
2a. DATE OF DEATH — MONTH / DAY / YEAR	July 29, 1986			2b. HOUR: 5:55P M
3. SEX	Male			
4. RACE	Caucasian			
5. DATE OF BIRTH — MONTH / DAY / YEAR	10	12	27	
6. AGE (IN YEARS LAST BIRTHDAY)	60 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Maryland			
7b. CITIZEN OF WHAT COUNTRY?	U.S.A.			
8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐				
9. BALTIMORE CITY OR COUNTY OF DEATH	Cecil, MD.			
10. CITY OR TOWN OF DEATH	Perry Point, Md.			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	VA Medical Center			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Retired			
12b. KIND OF BUSINESS OR INDUSTRY				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	Maryland			
13b. COUNTY	Frederick			
13c. CITY OR TOWN	Frederick			
13d. INSIDE CITY LIMITS? YES ☐ NO ☒				
13e. STREET ADDRESS / ZIP CODE	Rt. #2 /21701			
14. FATHER'S NAME — FIRST / MIDDLE / LAST	John	H.	Studebaker	
15. MOTHER'S MAIDEN NAME — FIRST / MIDDLE / LAST	Francis		Gilbert	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	No			
(IF YES, GIVE WAR OR DATES)				
16b. SOCIAL SECURITY NO.	213 24 8656			
17. INFORMANT — ADDRESS	VAMC, Perry Point, Maryland			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiac arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c) Alcoholic liver disease

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY — HOUR A.M. P.M. / MONTH / DAY / YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION — STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that ☒ (this hospital) attended the deceased from 7-28- 1986, to 7-29- 1986, that ☒ (we) last saw the deceased alive on 7-29- 1986, and that in ☒ (our) opinion death occurred on the date and hour and from the causes stated above. ☒ (We) (did) (did not) view the body after death.

22b. SIGNATURE / DEGREE — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒		22c. DATE SIGNED: 7-29-86
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	JOHN J. LONERGAN, M.D.	22e. ADDRESS: VAMC, Perry Point, Maryland

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION — CITY OR TOWN / COUNTY / STATE
Burial	Aug. 2, 1986	Lewistown Cemetery	Lewistown, Frederick, Maryland
24. FUNERAL DIRECTOR (NAME)	(ADDRESS)	25. ACCEPTED BY REGISTRAR	25a. REGISTRAR'S SIGNATURE
Dailey & Son Funeral Home, Frederick, Md.	1201 N. Market St.	AUG 13 1986	Julia Sanders-Randall

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

00-160651

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 23093
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Richard	MIDDLE: A.	LAST: Sutton	2a. DATE OF DEATH MONTH DAY YEAR: August 19, 1986		2b. HOUR: 10:10P M
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH DAY YEAR: DECEMBER 25, 1937	6. AGE (IN YEARS LAST BIRTHDAY): 48 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): GEORGIA	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: CECIL COUNTY MD.		
10. CITY OR TOWN OF DEATH: Perry Point	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): PERRY POINT VETERANS MEDICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): (RET) SHOP FOREMAN	12b. KIND OF BUSINESS OR INDUSTRY: U. S. ARMY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE: MD	13b. COUNTY: HARFORD	13c. CITY OR TOWN: HAVRE de GRACE	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET ADDRESS / ZIP CODE: 807 LAFAYETTE Street 21078	
14. FATHER'S NAME FIRST: DEWEY	MIDDLE	LAST: SUTTON	15. MOTHER'S MAIDEN NAME FIRST: MAUDE	MIDDLE	LAST: HOLLOWAY
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): YES	(IF YES, GIVE WAR OR DATES): VIETNAM	16b. SOCIAL SECURITY NO.: 257 58 8980	17. INFORMANT: MRS. CLEVA G. SUTTON	ADDRESS: SAME AS #13e	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Respiratory Failure

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Carcinoma of larynx with metastases

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that [X] (this hospital) attended the deceased from August 2, 19 86, to August 19, 19 86, that [X] (I) (we) last saw the deceased on the above [X] (I) (we) (did) [XXX] view the body after death August 19, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated.

22b. SIGNATURE: Prem Lal, M.D. DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 8-19-86

22d. PHYSICIAN'S NAME (TYPE OR PRINT): PREM LAL, M.D.

22e. ADDRESS: VA Medical Center, Perry Point, MD 21902

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: 23 AUGUST 86	23c. NAME OF CEMETERY OR CREMATORY: ANGEL HILL CEMETERY	23d. LOCATION CITY OR TOWN / COUNTY / STATE: HAVRE de GRACE, HARFORD CO., MD.

24. FUNERAL DIRECTOR NAME / ADDRESS: MITCHELL FUNERAL HOME, Havre de Grace, MD 21078

25a. DATE REC'D BY REGISTRAR: AUG 21 1986

25b. REGISTRAR'S SIGNATURE: Erika Davidson-Roberts

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

000-16438

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

86 23094 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Roberta — MIDDLE: L. — LAST: Walls

2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] — MONTH 8 DAY 23 YEAR 19 86

2b. HOUR: M

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH: MONTH Jan. DAY 5, YEAR 1951

6. AGE (IN YEARS LAST BIRTHDAY): 35 YRS.

IF UNDER 1 YR. MONTHS / DAYS — IF UNDER 24 HRS. HOURS / MIN.

2c. DATE PRONOUNCED DEAD: MONTH 8 DAY 23 YEAR 19 86

2d. HOUR: 7:45P M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Elkton, Md.

7b. CITIZEN OF WHAT COUNTRY? U.S.A.

8. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Cecil County MD.

10. CITY OR TOWN OF DEATH: Elkton

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Union Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Inspector-Manufacturing

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md.

13b. COUNTY: Cecil

13c. CITY OR TOWN: Elkton

13d. INSIDE CITY LIMITS? YES [X] NO [ ]

13e. STREET ADDRESS: 133 N. Tartan Drive 21921

14. FATHER'S NAME — FIRST: Lewis — MIDDLE: — LAST: Walls

15. MOTHER'S MAIDEN NAME — FIRST: Martha — MIDDLE: — LAST: Craig

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): no

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 213-58-0720

17. INFORMANT: Mr. & Mrs. John H. Craig — ADDRESS: P. O. Box 85 Galena, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Pulmonary thromboemboli

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

Obesity

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES [X] NO [ ]

21a. EXTERNAL CAUSE WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ],

ACTUAL SIGNATURE: Charles P. Kokes

TITLE (SPECIFY): M.D. Assistant MEDICAL EXAMINER

DATE SIGNED: 8/24/86

EXAMINER'S NAME (TYPE OR PRINT): Charles P. Kokes, M.D. ADDRESS: 111 Penn St. Balto.MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 8-27-86

23c. NAME OF CEMETERY OR CREMATORY: Elkton Cem.

23d. LOCATION CITY OR TOWN: Elkton COUNTY: Cecil STATE: Md.

24. FUNERAL DIRECTOR (NAME) Lee Funeral Home, P.A. ADDRESS Elkton, Md

25a. DATE REC'D. BY REGISTRAR: AUG 27 1986

25b. REGISTRAR'S SIGNATURE

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

00-14956

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 23095
REG. NO.

Field	Entry
1. DECEASED NAME (TYPE OR PRINT) — FIRST / MIDDLE / LAST	JOHN SCOTT WELLS
2a. DATE OF DEATH — MONTH DAY YEAR	August 5, 1986
2b. HOUR	10:10am
3. SEX	Male
4. RACE	White
5. DATE OF BIRTH — MONTH DAY YEAR	July 13, 1929
6. AGE (IN YEARS LAST BIRTHDAY)	57 YRS
IF UNDER 1 YEAR — MONTHS / DAYS	
IF UNDER 24 HRS — HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Elkton, Md.
7b. CITIZEN OF WHAT COUNTRY?	U.S.A.
8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	Married
9. BALTIMORE CITY OR COUNTY OF DEATH	Cecil MD.
10. CITY OR TOWN OF DEATH	Perry Point, Md.
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	VA Medical Center
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Audio Repair
12b. KIND OF BUSINESS OR INDUSTRY	Bd. of Ed.
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	Md.
13b. COUNTY	Cecil
13c. CITY OR TOWN	North East
13d. INSIDE CITY LIMITS? YES ☐ NO ☒	No
13e. STREET ADDRESS / ZIP CODE	2919 Turkey Pt. Rd. 21901
14. FATHER'S NAME — FIRST MIDDLE LAST	Charles Jackson Wells
15. MOTHER'S MAIDEN NAME — FIRST MIDDLE LAST	Marguerite Smith
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	Navy 1947-1950
16b. SOCIAL SECURITY NO.	212-26-3702
17. INFORMANT — ADDRESS	Marion W. Wells, 2919 Turkey Pt. Rd. North East, Md. 21901

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Aspiration of gastric contents	
DUE TO, OR AS A CONSEQUENCE OF (b)	Congestion and edema of lungs	
DUE TO, OR AS A CONSEQUENCE OF (c)	Bronchopneumonia, lower lobes	

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

911

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☒ NO ☐
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that X (this hospital) attended the deceased from July 31, 19 86 to August 5, 19 86 XXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX nd that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE Roy W. Chesnut, M.D.
DEGREE
ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒
22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROY W. CHESNUT, M.D.
22e. ADDRESS VA Medical Center, Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	8-8-86	St. Mary Anne's	North East Cecil Md.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Crouch Funeral Home, North East, Md.	AUG 11 1986	Julia Davidson

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP______

DHMH - 16 60M 7/84
(VRA 15, 4)

00-15272

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be placed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 23076
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	WILLIAM H WILLIAMS	2a. DATE OF DEATH MONTH DAY YEAR	AUGUST 7, 1986	2b. HOUR	7:00P M
3. SEX	M	4. RACE	B	5. DATE OF BIRTH MONTH DAY YEAR	8 7 1897
6. AGE (IN YEARS LAST BIRTHDAY)	89 YRS	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Md.	7b. CITIZEN OF WHAT COUNTRY?	USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	
9. BALTIMORE CITY OR COUNTY OF DEATH	Cecil MD.				
10. CITY OR TOWN OF DEATH	PERRY POINT, MD	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	VA MEDICAL CENTER	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Retired
12b. KIND OF BUSINESS OR INDUSTRY	Civil Service				

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Md.	Harford	HavreDeGrace	YES [X] NO [ ]	810 Garfield Road 21078

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
William Williams	Molly Whims

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
Yes	1942-1943	220-02-0607	Virginia Williams same as above

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) RENAL FAILURE
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b) GANGRENE OF LEG
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (X) (this hospital) attended the deceased from DECEMBER 18 19 79 to AUGUST 7 19 86, that X (we) last saw the deceased alive on AUGUST 7 19 86, and that in XX (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did XXXXX) view the body after death.

22b. SIGNATURE DEGREE	22c. DATE SIGNED
ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
LOUISE SULTAN, M.D.	VA MEDICAL CENTER, PERRY POINT, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	8/13/86	Union United Methodist	Aberdeen Harford Md.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Arnold Boren 353 Fountain St Hg	AUG 14 1986	